abusers; to the Committee on Labor and Human Resources.

By Mr. LIEBERMAN (for himself, Mr. JEFFORDS, Mr. CHAFEE, Mr. BREAUX, Ms. COLLINS, and Mr. ROCKEFELLER):

S. 795. A bill to improve the quality of health plans and health care that is provided through the Federal Government and to protect health care consumers; to the Committee on Finance.

By Mr. TORRICELLI (for himself and Mrs. FEINSTEIN):

S. 796. A bill to reduce gun trafficking, and for other purposes; to the Committee on the Judiciary.

By Mr. CHAFEE (for himself, Mr. BAUCUS, and Mr. KENNEDY):

S. 797. A bill to amend the John F. Kennedy Center Act to authorize the design and construction of additions to the parking garage and certain site improvements, and for other purposes; to the Committee on Environment and Public Works.

By Mr. WARNER:

S. 798. A bill to establish a Commission on Information Technology Worker Shortage; to the Committee on Labor and Human Resources.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. LEAHY (for himself, Mr. WELLSTONE, Mr. LEVIN, Mr. JEFFORDS, Mr. MOYNIHAN, Mr. LIEBERMAN, Mr. FEINGOLD, and Mr. DODD):

S. Con. Res. 28. A concurrent resolution expressing the sense of Congress that the Administrator of the Environmental Protection Agency should take immediate steps to abate emissions of mercury and release to Congress the study of mercury required under the Clean Air Act, and for other purposes; to the Committee on Environment and Public Works.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. REID (for himself, Mr. GRASSLEY, and Mr. GLENN):

S. 779. A bill to amend title XVIII of the Social Security Act to increase the number of physicians that complete a fellowship in geriatric medicine and geriatric psychiatry, and for other purposes; to the Committee on Finance.

THE MEDICARE PHYSICIAN WORKFORCE ACT OF 1997

S. 780. A bill to amend title III of the Public Health Service Act to include each year of fellowship training in geriatric medicine or geriatric psychiatry as a year of obligated service under the National Health Corps Loan Repayment Program; to the Committee on Labor and Human Resources.

THE GERIATRICIANS LOAN FORGIVENESS ACT OF 1997

Mr. REID. Good morning Mr. President. I come to the floor today to offer two bills which are written to address the national shortage of geriatricians we are experiencing in this country. A problem I am sorry to say that is getting worse, not better. I am pleased to have as original cosponsors of my bills Senator GRASSLEY, the distinguished Chairman of the Senate Special Committee on Aging and Senator GLENN, also a member of the Aging Committee, one for whom I have tremendous respect and regard.

Our Nation is growing older. Today, life expectancy for women is 79, for men it is 73. While the population of the United States has tripled since 1900, the number of people age 65 or older has increased 11 times, to more than 33 million Americans. By 2030, this group is projected to double in size to nearly 70 million.

Mr. President, I first became concerned about this problem when a read a report issued by the Alliance for Aging Research in May of 1996 entitled, ''Will you Still Treat Me When I'm 65?'' The report concluded that there are only 6,784 primary-care physicians certified in geriatrics. This number represents less than one percent of the total of 684,414 doctors in the United States. The report goes on to state that the United States should have at least 20,000 physicians with geriatric training to provide appropriate care for the current population, and as many as 36,000 geriatricians by the year 2030 when there will be close to 70 million older Americans.

The bills I am introducing today, the Medicare Physician Worforce Improvement Act of 1997 and the Geriatricians Loan Forgiveness Act of 1997, aim—in modest ways and at very modest cost—to encourage an increase in the number of trained doctors seniors of today and tomorrow will need, those with certified training in geriatrics.

One provision of the Medicare Physician Workforce Improvement Act of 1997 will allow the Secretary of Health and Human Services to double the payment made to teaching hospitals for geriatric fellows capping the double payment to be provided to a maximum of 400 fellows per year. This is intended to serve as an incentive to teaching hospitals to promote and recruit for geriatric fellows.

Another provision directs the Secretary of Health and Human Services to increase the number of certified geriatricians appropriately trained to provide the highest quality care to Medicare beneficiaries in the best and most sensible settings by establishing up to five geriatric medicine training consortia demonstration projects nationwide. In short, allow Medicare to pay for the training of doctors who serve geriatric patients in the settings where this care is so often delivered. Not only in hospitals, but also ambulatory care facilities, skilled nursing facilities, clinics, and day treatment centers.

The second bill I am offering today, The Geriatricians Loan Forgiveness Act of 1997 has but one simple provision. That is to forgive $20,000 of education debt incurred by medical students for each year of advanced training required to obtain a certificate of added qualifications in geriatric medicine or psychiatry. My bill would count their fellowship time as obligated service under the National Health Corps Loan Repayment Program.

Mr. President, the graduating medical school class of physicians in 1996 reported they had incurred debts of $75,000 on average. My bill will offer an incentive to physicians to pursue advanced training in geriatrics by forgiving a small portion of their debt.

Last year Medicare paid out more than $6.5 billion to teaching hospitals and academic medical centers toward the costs of clinical training and experience needed by physicians after they graduate from medical school. It is ironic, only a tiny fraction of those Medicare dollars are directed to the training of physicians who focus mainly on the needs of the elderly. Of over 100,000 residency and fellowship positions that Medicare supports nationwide, only about 250 are in geriatric medicine and psychiatry programs. Existing slots in geriatric training programs oftentimes go unfilled. With 518 slots available in geriatric medicine and psychiatry in 1996, only 261, barely one-half of them were filled.

By allowing doctors who pursue certification in geriatric medicine to become eligible for loan forgiveness, and by offering an incentive to teaching institutions to promote the availability of fellowships, and recruit geriatric fellows, my bills will provide a measure of incentive for top-notch physicians to pursue fellowship training in this vital area.

We must do more to ensure quality medicine today for our seniors and it is certainly in our best interest to prepare for the future when the number of seniors will double. Geriatric medicine requires special and focused training. Too often, problems in older persons are misdiagnosed, overlooked, or dismissed as the normal result of aging because doctors are not trained to recognize how diseases and impairments might appear differently in the elderly than in younger patients. One need only look at undiagnosed clinical depression in seniors or the consequences of adverse reaction to medicines to see how vital this specialized training really is. This lack of knowledge comes with a cost, in lives lost, and in unnecessary hospitalizations and treatments.

We need trained geriatricians to train new medical students. Of the 108 medical schools reporting for the 1994 to 1995 academic year, only 11 had a separate required course in geriatrics, 53 offered geriatrics as an elective, 96 included geriatrics as part of another required course and one reported not offering geriatrics coursework at all. Mr. President, this is simply not good enough.

In a country where by 2030, 1 in 5 citizens will be over the age of 65, there are only two departments of geriatrics at academic medical centers across the entire country. Yet, every academic medical center has a Department of Pediatrics. This just does not seem to make sense to me. While certainly no